

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 02-11	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 11/01/02	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 441.15	7. FEDERAL BUDGET IMPACT: a. FFY 2003 \$ 560,000 b. FFY 2004 \$ 700,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 20.13.1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): None

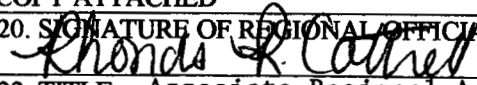
10. SUBJECT OF AMENDMENT:
Payment for Home Health Services

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☒ OTHER, AS SPECIFIED: Review delegated
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED to Commissioner, Department for Medicaid
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Frances McGraw Eligibility Policy Branch Department for Medicaid Services 275 East Main Street 6W-C Frankfort, Kentucky 40621
13. TYPED NAME: Mike Robinson	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 12/16/02	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 16, 2002	18. DATE APPROVED: June 24, 2003
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: November 1, 2002	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Rhonda R. Cottrell	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

Approved with the following corrections to Items 8 and 9:
Item 8 changed to read: "Attachment 4.19-B, Pages 20.13 and 20.13.1"
Item 9 changed to read: "Attachment 4.19-B, Page 20.13"

X. Home Health Agency Services

(1) The following home health services are paid in accordance with a fee schedule established by the state Medicaid agency, not to exceed billed charges:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

(2) Enteral nutritional products and disposable medical supplies shall be reimbursed based on costs as submitted on an annual cost report. Providers shall be paid an interim rate determined by multiplying a provider's facility-specific cost to charge ratio by its billed charges. Interim payments shall not exceed submitted charges and will be settled back to actual cost at the end of the home health agency's fiscal year, subject to lower of costs or charges. Interim payments will be settled back to allowable cost within 18 months following the end of the agency's fiscal year. Allowable costs will be based on audited or desk reviewed cost reports and determined in accordance with Medicare reimbursement principles. Cost reports for each of the home health agencies described in sections (3), (4), and (5) must be received by the Department within five (5) months of the close of the agency's fiscal year (May 31).

Public providers will not be subject to the lower of cost or charges and will be reimbursed their total allowable cost for enteral nutritional and disposable medical supplies.

(3) Payment to a new home health agency for the services described in (1) will be in accordance with the methodology described in (1). New home health agencies will be paid for enteral nutritional products and disposable medical supplies on an interim basis by multiplying their billed charges for these products by seventy (70) percent. A new home health agency will be held to the seventy (70) percent threshold until a cost report is received by the state Medicaid agency. A home health agency that did not participate under the current ownership or a previous ownership in the prior year will be considered a new home health agency. A new home health agency will be reimbursed as described above until a cost report is received by the department, no later than May 31 prior to the rate year beginning July 1.

(4) Payment to an out of state home health agency for the services described in (1) will be in accordance with the methodology described in (1). Out of state agencies will be paid for enteral nutritional products and disposable medical supplies by multiplying billed charges by eighty (80) percent.

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- (5) For home health services provided by licensed county health department home health agencies, a supplemental payment which represents the difference between the estimated costs of home health services for the eight month period beginning November 1, 2002 and ending June 30, 2003 and the amount of payments made by the Department for these services under the flat fee reimbursement as describe in (1) will be made.

Using cost reports filed with the Department, the Department will calculate the unit cost for a service listed under (1) and compare the unit cost to the rate per unit as described in (1). The supplemental payment will equal the difference between the cost per unit of service multiplied by the number of units of service provided during the period. In this way, the Department shall assure public providers reimbursement for their total allowable costs.

If a provider's costs as estimated from the annual cost report are less than the estimated payments, the Department will recoup any excess payments.

- (6) Services provided by County Health Department Home Health Agencies. For the fiscal period beginning July 1, 2003 and for subsequent periods beginning July 1, supplemental payments will be made on a quarterly basis. The supplemental payments will be compared to the provider's annual cost report and adjustments made as described in (5) above.